Gender Mainstreaming in Health –
Lessons Learned from the
"Tanzanian German Programme to Support Health"

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List of abbreviations

AIDS	Acquired Immune Deficiency Syndrome
BAKWATA	Baraza Kuu la Waislamu Tanzania (Islamic Council of Tanzania)
BMZ	Bundesministerium für wirtschaftliche Zusammenarbeit und Entwicklung/ German Federal Ministry for Economic Co-operation and Development
CBHI	Community-Based Health Initiatives Project
CBO	Community Based Organisation
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CHF	Community Health Fund
CHMT	Council Health Management Team
DANIDA	Danish International Development Agency
DHQM	District Health and Quality Management
FGC	Female genital cutting
FGM	Female genital mutilation
GTZ	Gesellschaft für Technische Zusammenarbeit / German Technical Cooperation
HF	Health Financing
HIV	Human Immunodeficiency Virus
HRBA	Human rights based approach
ICESCR	International Covenant on Economic, Social and Cultural Rights
MACC	Multi-Sectoral HIV/AIDS Control Component [of the TGPSH]
MCDGC	Ministry of Community Development, Gender and Children
MDG	Millennium Development Goals
MOHSW	Ministry of Health and Social Welfare
MOEVT	Ministry of Education and Vocational Training
NGO	Non-Governmental Organisation
PASHA	Prevention and Awareness in Schools of HIV& AIDS
PMTCT	Prevention of Mother-To-Child-Transmission [of the HIV]
PPP	Public Private Partnership
STI	Sexually transmitted infections
SOSPA	Sexual Offences Special Provision Act
TACAIDS	Tanzania Commission for AIDS
TBA	Traditional Birth Attendant
TDHS	Tanzania Demographic and Health Survey
TGNP	Tanzania Gender Networking Programme
TGPSH	Tanzanian German Programme to Support Health
THIS	Tanzania HIV/AIDS Indicator Survey
TQIF	Tanzania Quality Improvement Framework
TNCHF	Tanzania Network of Community Health Funds
URT	United Republic of Tanzania
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
WHO	World Health Organization
WLAC	Women's Legal Aid Centre

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Executive Summary

This report is based on a study conducted from August 4, 2008 to October 17, 2008 for the German Technical Cooperation (GTZ) within the framework of the “Tanzanian German Programme to Support Health” (TGPSH). The management of TGPSH commissioned the study as it intends to consolidate the attention paid to gender in the next programme phase. The objectives were to collect information on the current state of gender mainstreaming within the programme, assess the gender sensitivity of the activities within the six programme components and to provide recommendations for the way forward.

Information was gained from interviews and discussions with TGPSH staff as well as some nongovernmental organisations (NGOs) and development partners, from a review of relevant programme documents and research papers, and from participation in workshops and meetings.

The report begins with a clarification of the rationale for gender mainstreaming and on the particular questions to consider in gender and health. It also gives a short overview of the TGPSH for those not familiar with the programme. The second part of the report comprises the analysis of the Tanzanian political and legal context for gender mainstreaming, as well as a brief survey of the health situation in Tanzania from a gender perspective. Findings from the gender analysis within TGPSH and recommendations for the programme as a whole, as well as for each of the six programme components, are elaborated in the third part.

The analysis found that gender mainstreaming was well established in the programme both in regards to internal policies as well as across the spectrum of supported interventions. Overall, however, it was noted that the approach could still benefit from a more systematic application and reflection in routine planning, implementation and monitoring. Gender sensitivity in the areas of sexual and reproductive health and HIV and AIDS has long been a hallmark of the German Development Cooperation. Beyond this, however, the efforts being made to pay attention to gender sensitivity in areas such as contractual arrangements with service providers, health insurance schemes and quality management were found to innovative.

The document identified the need for greater dialogue on how gender issues can impinge upon the many facets of a public health programme and how a gender sensitive perspective can enrich interventions. Consequently it was decided to put together this abridged version for public health practitioners to facilitate more in-depth exchange on gender mainstreaming in public health practice.

1 Framework

1.1 What is gender mainstreaming and why is it important?

Gender mainstreaming has been an explicit strategy of International Development Cooperation at least since the 4th World Conference on Women in 1995 in Beijing. It grew out of national and international policy activities to promote gender equality and contains reflections of the exploration of the interrelation between gender discrimination, poverty and ill health. In the 1970s and 1980s, "Women in Development" initiatives struggled to make headway in advocating the interests of women in development work.[1] Later on, the terminology and focus shifted from an explicit mentioning of "women" to "gender", acknowledging the importance of both women and men in changing gender relationships.

The concept of gender mainstreaming

Gender, in contrast to biological sex, refers to the social roles adopted by and attributed to men and women. There are multiple different gender roles which vary according to different cultural, historical and economic circumstances. Gender roles are often closely intertwined with the rights and obligations of women and men within a given society, as well as the power relations between them. Since these roles are learned through socialisation, they can gradually be changed and change over time.[2]

Gender mainstreaming can be understood as a strategy for making the concerns and experiences of both men and women integral to the design, implementation, monitoring and evaluation of policies and programmes in all spheres.[3] Gender is a cross-cutting issue in German and International Development Cooperation. The concept on gender equality is a binding guideline for the formulation of official German development co-operation by the BMZ and its implementing agencies like GTZ. According to the GTZ corporate strategy on gender mainstreaming, the following definition is binding in all policy areas of the German Federal Government since 1999:

> *"The term "gender mainstreaming" denotes the process and the procedure by which the gender perspective is to be adopted into overall policy. This means carrying out the development, organisation and evaluation of policy-making processes and measures in such a manner as to ensure that in every policy field and at all levels the baseline conditions and the impacts on men and women are taken into account in order to make it possible to work toward the goal of real equality between men and women. This process is to be a component of the routine operation of all departments and organisations involved in policy-making processes."*

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[1]Cf. http://www.genderkompetenz.info/eng/gendermainstreaming/bases/history/, accessed Nov. 14, 2008.
[2]Cf. BMZ (2001): 5, Walter (2001): 17.
[3]Cf. UNDP (2007): 38.

Gender equality and women empowerment

The empowerment of women often forms an important aspect of gender mainstreaming, because in many cases women are disadvantaged in relation to men. However, it is important to note that gender mainstreaming is not only centred on women. Gender bias may manifest itself against both women and men, and in order to change gender relations, both men and women need to be involved.[4]

Gender equality means that women and men enjoy the same status. This implies that they have equal conditions for exercising their human rights and realising their potential to contribute to national, political, economic, social and cultural development. It does not mean that women and men will become the same, but that their rights, responsibilities and opportunities will not depend on whether they are born male or female. Gender equality refers to the absence of discrimination on the basis of gender, and to equal treatment of women and men in laws and policies.[5]

The concept of **gender equity** refers to parity, fairness and justice in terms of gender relations. It acknowledges the differences in women and men's living circumstances and allows for preferential treatment and affirmative action, addressing the fact that in many societies women are, and have been, systematically discriminated against.[6] There are no universally agreed definitions; According to the BMZ concept, one of the important achievements of the Beijing conference was to replace the concept of gender equity with gender equality. This report uses the term gender equality.

Gender-specific needs and strategic interests

Different gender concepts set different priorities and employ varying methods of gender analysis. Amongst the different approaches common elements can be found: firstly, in regards to the timing it is generally accepted that undertaking a gender analysis prior to planning a programme is particularly useful for the development of gender sensitive indicators etc. The gender analysis should cover the situation at macro, meso and micro levels, i.e., the national legal and regulatory framework, the structure of sectoral services and the impact on men and women's access, as well as typical divisions of labour at the household level and their impact on access to services.[7] For a gender analysis, it can also be useful to distinguish between gender-specific needs and strategic interests. Gender-specific needs refer to the more immediate and every-day needs of men and women, (e.g., the need to access a health station and receive treatment) and are often symptomatic of existing inequalities.[8]Strategic interests are related to the long-term objective of gender equality and refer to the structural causes of the prevailing inequalities.

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[4]Cf. ibid.: 5.
[5]Combined definition UNDP (2007): Status of Women Canada (1998),Walter (2001) and WHO (2001)/ Cottingham et al (2001): 43.
[6]Walter (2001): 18; cf. also WHO (2001)/ Cottingham et al (2001): 43.
[7]Cf. DAC (2002): 6, BMZ (2001): 10.
[8]Cf. BMZ (2001): 10.

Gender mainstreaming in the international development context

UNIFEM, the **United Nations Development Fund for Women** spearheads the international effort to foster women's empowerment and gender equality as its core business. The reach of the call to gender mainstream extends far beyond UNIFEM however, and extends to the entire international community working across all sectors to reduce poverty and achieve the Millennium Development Goals. The need to address gender inequality has been emphasized by the Millennium Declaration which contains both an explicit gender equality Goal and recognition that gender equality is important for achieving all of the Goals. The Human Development Reports of recent years continue to stress that gender equality is at the core of whether the Goals will be achieved – from improving health and fighting disease, to reducing poverty and mitigating hunger, to expanding education and lowering child mortality, to increasing access to safe water, to ensuring environmental sustainability.

The German Federal Ministry for Economic Co-operation and Development argues that "as the majority of the poor are women and as the causes of their poverty are rooted in their gender-specific discrimination, consideration of gender roles is an essential prerequisite for successful and sustainable poverty alleviation."[9] The foundations underpinning gender mainstreaming run far deeper, with the International Conference on Population and Development (Cairo, 1994), the Fourth World Conference on Women (Beijing, 1995), building on the convention on the Elimination of all Forms of Discrimination Against Women (1979) and the World Conference on Human Rights (Vienna, 1993) all highlighting the importance of gender equality in all areas of social and economic development. The Beijing Declaration pledged that, "It is essential to design, implement and monitor, with the full participation of women, effective, efficient and mutually reinforcing gender-sensitive policies and programmes, including development policies and programmes, at all levels that will foster the empowerment and advancement of women".[10]

The interface between gender and health, using the Tanzanian example

The WHO strategy for integrating gender analysis and action into its work states "in order to ensure that women and men of all ages have equal access to opportunities for achieving their full health potential and health equity, the health sector needs to recognise that they differ in terms of both sex and gender. Because of social (gender) and biological (sex) differences, women and men face different health risk, experience different responses from health systems and their health-seeking behaviour, and health-outcomes differ".

Information on women`s health often reflects the reality of gender inequality. Key documents for

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[9]Cf. BMZ (2001): 7.

[10]Beijing declaration (1995): Point 19. The attending states are listed in the report of the 4th world conference on women, which is

the Tanzanian context are the 2004-05 Tanzania Demographic and Health Survey (TDHS), the 2007-08 Tanzania HIV/AIDS and Malaria Indicator Survey (THMIS) draft, the 2005 WHO study on gender-based violence, and other WHO statistics.

Whilst life expectancy is higher for women than men in most countries, a number of health and social factors combine to create a lower quality of life for women (WHO, 2009). In Tanzania the total fertility rate is 5.3 births per woman in 2006 according to WHO data.[11] The median age at the birth of the first child is 19.4 years. More than half of the women in Tanzania give birth before they are 20 years old, a rate which has not changed over the past 15 years.[12] While 94% of the women who gave birth in the five years before the THDS (2004-05) used antenatal care at least once, only 46 % of all births were attended by health professionals.[13] Traditional birth attendants assist 19% of deliveries, and relatives and other untrained people assist 31% of births. Three percent of births are delivered without assistance. A mother's education and wealth are associated with the type of delivery assistance: while 31% of women with no education deliver under the assistance of health professionals, the rate is 84% among women with some secondary education. Also, 87% of births by women in the highest wealth quintile are professionally assisted, in comparison to 31% of births to women in the lowest quintile.[14] The maternal mortality rate is estimated as 578 maternal deaths per 100 000 live births in the 2004-05 Survey, a situation that has changed little since the previous figures of 529 maternal deaths per 100 000 in 1996.[15]
On mainland Tanzania, 5.7% of adults between age 15 and 49 are infected with HIV, the prevalence being higher among women in the national average (6.6%, vs. 4.6% for men) (THMIS 2007/08)

Female genital cutting (FGC) is practised in some regions of Tanzania. While the overall prevalence of FGC in Tanzania is 15%, there are great regional variations, with the highest prevalence in Manyara at 81%. In all TGNP programme regions the prevalence is at or below 1%, except for Tanga where it is 23%.[16]

The ability of women to make decisions affecting the circumstances of their own lives is an essential aspect of empowerment. The THDS (2004-05) includes women's participation in household decision making as an indicator of women's status. Women were asked to assess their participation in five types of decisions.[17] It found that only 42.8% of currently married women, and 43.3% of unmarried women, considered that they

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accessible e.g. at http://www.un.org/esa/gopher-data/conf/fwcw/off/a—20.en.

[11]WHO core health indicators, online: http://www.who.int/whosis/database/, accessed Sept. 8, 2008. THDS (2004-05): 57 and TGNP and Macro International Inc. (2007): 6 give 5.7, pointing out that there has been almost no change in this rate since 1996. According to THDS (2004-05): 57, this is among the highest rates in Sub-Saharan Africa.

[12]THDS (2004-05): xvii.

[13]TGNP and Macro International Inc. (2007): 8, THDS (2004-05): 141.

[14]THDS (2004-05): 141.

[15]THDS (2004-05): 261.

[16]TGNP and Macro International Inc. (2007)

[17] These were: 1) decisions about their own health care, 2) about large household purchases, 3) about every-day household purchases, 4) about visits to family and friends, 5) about what food to cook every day. Cf. THDS (2004-05: 46, 48.

would usually have the final say in decisions regarding their own health care. 16.3% of the married women would take decisions about their own health-care jointly with their husband, but for 38.5%, the husband only would take these decisions. For a remaining 2.1% of the married women, "someone else only" would take these decisions, and 0.3% would take health-care decisions jointly with someone else than the husband.[18] In comparison, "someone else only" has the final say in health-care decisions for 48.6% of the unmarried women, and 6.5% of them take these decisions jointly with someone else.[19] Only 56% of men believe that a wife should be able to have a say in how her own earnings are spent, while 54% believe she should be able to have a say in how many children to have.[20]

The THDS also inquired about women's and men's attitudes towards a wife's right to refusing sex with her husband. The respondents were asked about a wife's justification for refusing sex in four situations: if the wife knows that her husband has a sexually transmitted disease, if she knows that he has sex with other women, if she has recently given birth, and if she is tired or not in the mood. 62.8 % of the women (compared to 62.3% of the men) agreed that all of the specified reasons were valid justifications for refusing sex, while 5.9% of the women (compared to 3.7% of the men) agreed to none of the reasons.[21]

While literally the expression "gender-based violence" could be understood to denote any form of violence involving an aspect of gender-discrimination (e.g. against people with different sexual orientations, both male and female), it is often used to refer in general to violence against women.[22] The UNFPA Gender Theme Group in 1993 defined gender-based violence as follows: "Gender-based violence is violence involving men and women, in which the female is usually the victim, and which is derived from unequal power relationships between men and women. [...]"[23] The United Nations Declaration on the Elimination of Violence against Women provides a basis for defining violence against women. In its Article 1, it states that "violence against women" means "any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life."[24] According to Art. 2 such violence against women encompasses, but is not limited to, battering, rape, sexual abuse, sexual harassment and intimidation, dowry-related violence, marital rape, female genital mutilation, trafficking in women and forced prostitution.[25]

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[18]THDS (2004-05): 46. The exact differentiation is "currently married or living together" and "not married".
[19]Ibid.
[20]However, the THDS points out that the meaning of the latter is unclear, because some of the respondents may have believed that only God has a say over how many children a couple might have. THDS (2004-05): 47f.
[21]Ibid.: 54f.
[22]Cf., e.g., www.unfpa.org/intercenter/violence/intro.htm.
[23]www.unfpa.org/intercenter/violence/intro.htm, accessed Nov. 16, 2008.
[24]United Nations A/RES/48/104 of 20th December 1993.
[25]Cf. UN A/RES/48/104 of 20th December 1993. Cf. www.unfpa.org: "Gender-based violence: A price too high", accessed Nov. 16, 2008.

The THDS reveals that 60% of women and 42% of men in Tanzania believe that wife beating is justified in at least one of these five situations: if a wife burns food, if she argues with her husband, if she goes out without telling her husband, if a wife neglects her children, or if she refuses to have sex with her husband. Women in rural areas are more likely to agree to justifications of wife beating than urban women. It is notable that women are more likely than men to report that they find violence against wives acceptable.

In a WHO multi-country study on women's health and domestic violence against women, which was conducted between 2001 and 2002 in Dar es Salaam and the Mbeya district, it was found that 41% of ever-partnered women in Dar es Salaam and 56% in Mbeya had ever experienced physical or sexual violence at the hands of a partner. 17% of ever-partnered women in Dar es Salaam and 25% in Mbeya had experienced severe physical violence, and 15% of ever-partnered women in Dar es Salaam compared to 19% in Mbeya were currently experiencing physical or sexual violence in an intimate relationship (in the past 12 months).[26] In both settings, women who had experienced physical or sexual violence were more likely to report current health problems than non-abused women.[27] About one out of ten respondents reported having experienced sexual abuse before the age of 15 years.

Summary of the importance of considering gender in a public health programme

It is important to consider gender in health programming for various reasons.

- Firstly, women and men have **different health problems because of biological reasons**: This holds particularly when it comes to sexual and reproductive health and the child-bearing function of the female sex. Male gender norms affect men's health by assigning them roles that promote risk-taking behaviour and cause them to neglect their health (WHO, 2008). The work traditionally undertaken by men can leave them vulnerable to industrial or other vocational health detriments and accidents.
- Secondly, **gender roles influence health-seeking, vulnerability and home-based care.** Practices and violence that are based on gender constructs can directly lead to health problems. Bargaining power over sexual relations has an impact on vulnerability to HIV and other sexually transmitted infections. Access to financial resources and bargaining power over household expenditures, which are determined, among other factors, by the gender-division of labour and the power relation between wife and husband, have a great impact on individual ability to seek health-care and treatment.[28] The gender division of labour also influences who takes care of the health of children, or who nurses sick people in the household and whether such work commands respect.
- The **health sector** can also be analysed **as a social institution upholding gender roles and norms**.

[26]Severe physical violence here refers to: being hit with a fist or something else, kicked, dragged, beaten up, choked, burnt on purpose, threatened with a weapon or had a weapon used against them. WHO (2005) fact sheet. The study was conducted in cooperation with the Muhimbili University College of Health Sciences, Dar es Salaam.

[27]Ibid.

For instance, health education messages may be addressed mostly to women, because they are seen as responsible for the health of family members. In many settings, the health sector assumes that all men and women are heterosexual, monogamous, and married, and anyone who does not conform to this pattern is viewed with disapproval.[29]

- Finally, in the health sector, as in any professional sector, **gender bias** may manifest **in education and career opportunities**.

1.2 Assessing the gender sensitivity of the Tanzanian German Programme to Support Health (TGPSH)

TGPSH started its activities in January 2003 as a joint programme of five organisations: German technical cooperation (GTZ), the German Development Bank (KfW), the German Development Service (DED), the Centre for International Migration (CIM) and Capacity Building International, Germany (InWEnt). The overall objective of the programme is "to improve the health and well-being of all Tanzanians, with a focus on those at most risk and to encourage the health system to be more responsive to the needs of the people".[30]

The programme comprises six components that reflect the priorities of the Health Sector Reform: District Health and Quality Management, Reproductive Health, Multisectoral AIDS control, Health Financing, Public Private Partnership, and Human Resources for Health. It is active in four out of 22 regions in the country: Tanga, Mbeya, Mtwara, and Lindi. These regions had already received German technical support through the project mode since the early 1980s.

To conduct this assessment strategy and programme documents were analysed and interviews and discussions held with international and local TGPSH staff. Furthermore, discussions were conducted with the gender focal person of the Ministry of Health and Social Welfare (MOHSW), as well as representatives of the United Nations Population Fund (UNFPA) and key civil society actors.

2 The Tanzanian context

In order to support partner country initiatives in the context of gender mainstreaming, it is important that the relevant legislation and policy framework, as well as civil society initiatives are known.

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[28] For Tanzania, this is very clearly reflected e.g. in the Demographic and Health survey 2004-05. Cf. section 2.2 below.
[29] Cottingham et al (2001): 84.
[30] This is also the goal of the Health Sector Reform Programme of the Tanzanian Government. Cf. http://www.tgpsh.or.tz

2.1 The political and legislative framework for gender mainstreaming

The Government of Tanzania has ratified a number of international human rights treaties and policy agreements related to women's rights and gender equality. Equal rights and non-discrimination are protected by the Tanzanian constitution, and the aim of achieving gender equality is included in a number of international and national policy documents which are listed in Annex 1.

Furthermore, the links to the Ministry responsible for Gender were analysed, as well as how well known their strategy documents are. In this case, the National Strategy for Gender Development defines specific objectives for all ministries, including activities, performance indicators, actors and timeframes. However, the general impression amongst the interview partners of this study was that the strategy is not very well known and is little used as a reference document.

The extent to which gender is anchored within the direct partners of the programme is also a key consideration: **MOHSW** has an overall **gender focal person**, as well as gender focal points in all departments.[31] While there is no special budget line for gender in the MOHSW, the topic is reflected in relevant budgets e.g. for reproductive health or vaccines.

The MOHSW in cooperation with UNFPA has developed a **checklist for integrating gender** into the Health Sector Strategic Plan III (HSSP III), which was already used during the last planning cycle and is a useful resource document.

In sum, the analysis showed that various policy papers of the Tanzanian government address gender aspects relevant in the health sector, albeit with a rather strong focus on women's health. It can however, be stated that most of the Tanzanian national gender objectives have some relevance to the work of TGPSH and form solid reference points for strengthening the programme's gender strategy and ongoing alignment within national priorities. The study further included a rapid assessment of the key non-governmental actors working on the subject and of the latest civil society developments towards gender equality. Such networks are recognised to provide invaluable fora for exchanging information and expertise, as well as for strengthening advocacy for legal and policy changes.

3 Part III: Findings within TGPSH and recommendations

3.1 A review of TGPSH policy documents

As a next step the following policy documents were reviewed: The BMZ Tanzania country concept of 2006, the Tanzania-German Co-operation Strategy for the Focal Area of Health including HIV& AIDS (2005) (the "sector strategy") and the TGPSH programme offers for the first and second programme phases.

The **country concept** in its overview of the development context of Tanzania has a paragraph on women, pointing out their importance for the economy, since many women are working in small-scale enterprises. It continues, however, to describe how the economic potential of Tanzanian women is hindered by the numerous socio-political and cultural disadvantages they continue to face. Furthermore, it observes that women are disproportionately affected by lack of access to basic social services like water, education and health and that they would profit economically and health wise from an improvement of health services and the water infrastructure.[32] The **country concept**, the **sector strategy** and the **TGPSH programme offer** with respect to health have in common that they all call for an improvement in "the health of selected groups of the population who are especially disadvantaged and at risk", or of "vulnerable groups".[33] Closer attention could be paid to defining who is exactly being referred to with the terms "those most at risk" or "the vulnerable". From a gender perspective, a more differentiated description of the various population groups would be desirable in order to avoid stereotyping, and in order to point out the particular difficulties that population groups with certain characteristics are typically facing.

3.2 General findings and recommendations for the Tanzanian German Programme to Support Health

This section starts with summarising the findings of the gender study which are assumed to be relevant for GTZ Tanzania and/or the entire TGPSH. It then moves on to findings and recommendations for the individual components.

Findings:

- Among TGPSH staff, there is generally a high awareness of the importance of gender, and various activities are planned with a gender-focus implicitly or explicitly.
- Some component leaders consider that a thorough mainstreaming of gender mainstreaming could serve to link the components more strongly and that joint reflection of how to go about it could further

[32]BMZ (2006): 3.
[33]Cf. BMZ (2006): 10, "Verbesserung des Gesundheitszustands besonders gefährdeter und benachteiligter ausgewählter Bevölkerungsgruppen", TGPSH programme offer: 1. Cf. also BMZ (2005): 5.

strengthen exchange, awareness and knowledge of each other's work.

- Preparation for international TGPSH staff prior to their work in Tanzania includes training on gender topic, but there is later, regular input. Dialogue with a gender specialist would be appreciated.
- Programme management observes an equal opportunities policy for employment and promotion of TGPSH staff[34].
- Terms of reference for TGPSH consultants do not generally include gender competence and know-how.
- Staff appreciate that some aspects of health-relevant Tanzanian legislation leave room for improvement when analysed from a gender perspective[35].
- There is a specific awareness of the importance of male involvement in sexual and reproductive and other health issues (male involvement in PMTCT, in peer education in schools, in discussions with traditional initiators and in theatre performances aimed at initiating behaviour change and promoting gender equality).

Recommendations:

- TGPSH should appoint a gender focal person who could join the DPG on gender.
- At the strategic level TGPSH could be more consistent in promoting the attention paid to gender equality in the Sector-Wide Approach and macro-policy frameworks, including Poverty Reduction Strategy Processes (PRSPs).
- Communication and exchange between the components can strengthen the gender perspective and benefit the programme outputs generally. For example:
  - gender-based violence could be discussed as a cross-cutting issue between the Reproductive Health, HIV& AIDS and DHQM components;
  - maternal mortality could be treated as a cross-cutting issue between the Reproductive Health, DHQM, Health Financing and PPP components when it comes to taking much needed action in the next programme phase.
- Consideration of gender sensitivity and impact on gender equality should be systematically included in planning, monitoring and evaluation – the MOHSW/UNFPA checklist on integrating gender in health planning to be used as a reference document.
- Realisation of some of the recommendations hereby presented could be included in the annual achievement agreements with staff members.
- The programme could engage more closely in networking on gender and health with other development partners and NGOs. The Men Engage Network has only been established recently but could represent a good starting point; The TNCHF network of TNCHF could also be made use of[36].

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[34] Interview with Dr. B. Schmidt-Ehry, August 28, 2008.

[35]Cf. above under II. Notably the illegality of homosexual relationships and the illegality of consensual sex under age 18 according to the SOSPA, and legislation on gender-based violence and abortion.

[36]TNCHF is part of the FemAct coalition.

- TGPSH should consider taking a more active role in alliances that advocate legal changes relevant to gender equality. The gender and equal opportunities policy for employment and promotion of TGPSH staff should be maintained.
- Gender equality should be made an explicit selection criterion for employment and participation in trainings and studies wherever GTZ can influence this.

Legal changes that could be advocated for from a gender perspective could begin with the attention given to the law on abortion given the importance of tackling maternal mortality. Irrespective of controversial views about women's *right* to abortion, unsafe abortion is known to be responsible for causing a considerable proportion of maternal deaths[37] TGPSH is currently addressing this problem by supporting training and provision of comprehensive post-abortion care by the reproductive health component. This is an important contribution which should be continued and intensified.

Beyond this, advocacy for amendment of SOSPA and the Law of Marriage Act as well as the Penal Code could also be considered: particularly regarding the legislation on sexual relationships in respect to rape and consensual sex of young people below 18 and the discrepancy in the legal age for marriage between the sexes. Advocating for amendments to the legislation on domestic violence could also be considered, [38]as too could the provision of legal advice in the workplace. This would be helpful in cases of sexual harassment and also when it comes to issues of confidentiality and people living with HIV facing threats of dismissal due to their status.

3.3 Multisectoral HIV& AIDS Control Component (MACC)

The objective of this component is that the population in the programme areas adopts increasingly preventive behaviour and makes use of the HIV and AIDS services offered by public or private providers.

Findings

- A new WHO guideline for mainstreaming gender in HIV& AIDS counselling and treatment was pre-tested by MOHSW in co-operation with WHO and GTZ/TGPSH.
- MACC promotes male involvement in the prevention of vertical transmission services (PMTCT)
- There is anecdotal evidence that women engage in “health facility shopping” to avoid undergoing VCT as part of antenatal care. MACC continues to work to counter the stigma and discrimination that surround HIV and AIDS.

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[37] The UN population division country profile for Tanzania in 2002 cites various studies indicating that between 17 and 21% of maternal deaths were directly related to abortion. Another study quoted there reported that in a sample of 300 women admitted to Muhimbili hospital for early pregnancy loss, 31% had had an abortion. Cf. UN country profile abortion: Tanzania (2002).

[38]Seeing that national legislation on abortion is stricter than the Maputo Protocol which Tanzania is also a party to, cf. above at 2.1.2. Women's lawyers NGOs in Tanzania advocate for raising the age of marriage to 18 for girls (cf. also the recommendations of the CEDAW committee), and for a specific law on domestic violence because the fact that so far the penal code has to be used for judging domestic violence constitutes a barrier for many women, who do not want a harsh punishment like a prison sentence imposed on their husbands. Cf. 2. 1. 6 above.

- Gender equity has been included in the AIDS policy guide for the Muslim Council (BAKWATA) which was developed in cooperation with the MAC component.[39]
- In Tanga Region, HIV awareness trainings specifically target female Madrassa teachers.
- WPP public and private sector trainings address also gender issues (e.g. HIV vulnerability).
- The WPP trainings have highlighted the extent of sexual harassment and corruption reported from the workplace. The sub-component of 'HIV WPPs in the public sector' is now discussing with the partners whether and how operational research on this topic can be carried out.

Recommendations

- Continue efforts to strengthen male involvement in the prevention of vertical transmission (formerly known as PMTCT); and to counter the stigma and discrimination that continue to hamper progress in responding to the epidemic.
- Continue the focus upon gender regarding the broader spectrum of HIV and AIDS interventions– for example, for men to play a greater role in the provision of home based care.
- Consider operational research on the prevalence of "health facility shopping" and sexual harassment in the workplace.
- Support the MOHSW in further adapting and implementing the WHO tool on gender mainstreaming in HIV/AIDS counselling and treatment in the Tanzanian context.
- Consider cooperating with legal aid NGOs for advice on sexual harassment at the workplace as well as legal advice for HIV+ people in general.
- Study and explore the Tanzanian AIDS Act for its potential to promote human rights and advocate for further expansion of human rights (e.g. revision of the legislation).
- Intensify the response to gender based violence, based upon existing studies.[40]

Experience shows that when HIV positive women disclose their status to their partner, regardless of the source of infection, they can face eviction and abandonment. This explains why some women try to attend antenatal care in health facilities where HIV testing isn't offered.

While gender equality and women empowerment are not explicitly part of the training curricula for WPP trainings in the public and private sector, the trainings address gender aspects such as the higher vulnerability of women for HIV. Incidences of sexual harassment ("rushwa") at the workplace were reported to be a frequent source of discussion at such trainings, and are acknowledged to be widespread.[41]

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[39] BAKWATA (2007): 7, point 3.1.5.1: "BAKWATA will give priority and spearhead initiatives that promote equitable gender relations, human dignity in health development according to Islamic principles and discourage socio-cultural practices or life styles that predispose people to HIV/AIDS and STIs."

[40] Cf. recommendation from recent WHO (2005) study and WLAC presentation on gender based violence at Men Engage Tanzania meeting on 17th September 2008. WLAC might be a good partner for this topic.

[41] "Rushwa" is Kiswahili for corruption. male superiors demand sexual favours from women for employment and promotion.

The topic of sexual violence is closely linked to HIV & AIDS: Sexual violence increases vulnerability to HIV infection. It is also an expression of the gendered patterns of power which generally tend to increase women's specific vulnerability to HIV infection.[42] There are anecdotal reports that misconceptions about HIV&AIDS may contribute to a rise in sexual violence against children and young girls.[43]

TGPSH could place stronger emphasis upon ensuring that post-exposure prophylaxis is made available to victims of sexual violence as well as emergency contraception. The Tanzanian AIDS Act in Article 26 regulates post-exposure prophylaxis for health workers, but not for victims of sexual violence and other people with potential exposure to HIV.[44] Another point would be to consider how the topic of sexual violence can be integrated into VCT counselling and addressed in the training of VCT counsellors.[45]

3.4 Reproductive Health and PASHA

The objective of the Reproductive Health Component is that the population of the programme regions, in particular young people, have access to information on sexual and reproductive health and to increasingly use selected good quality reproductive health services. The component collaborates with different stakeholders in order to provide adolescents with sexual and reproductive health information and broadening contraceptive choice. This involves cooperation with traditional initiators of both sexes and community education through theatre, as well as training of health personnel, and training of community-based distributors (CBDs). The latter are male and female community members who are supposed to provide information on family planning and distribute contraceptives within their respective community.

PASHA (Prevention and Awareness in Schools of HIV& AIDS) is part of the Reproductive Health Component and supports peer education activities in primary and secondary schools, as well as the implementation of school based counselling services. Activities include sensitisation of the school community, the training of male and female school counsellors that the students elected themselves, the establishment of school-based counselling services and the introduction of peer education programmes.

Findings

– Gender relations are a topic in peer education on sexual and reproductive health in schools, in theatre plays and in the cooperation with traditional initiators. Partnership and sexual relations are discussed as

[42] Cf. Lary et al (2004)
[43] Cf. Lalor (2004) (in: URT (2005)
[44] UNAIDS (2008): 12: “Article 26/ Comment 41: UNAIDS welcomes the explicit reference to the entitlement of healthcare workers to post-exposure prophylaxis in the event of an exposure to HIV during the course of their duties. UNAIDS recommends that this article include a subsection which indicates that survivors of sexual violence, and others who have possibly been exposed to HIV, be entitled to access post-exposure prophylaxis, and that HIV-related information and services be available through rape and trauma centres.”
[45] Cf. the recommendation to integrate competence in handling cases of sexual violence into quality management.

something that should be balanced and reciprocal.[46]

– The numbers of peer educators in schools, of school counselling teachers, and of the actors in community theatre plays are usually gender-balanced.[47]
– There is a male need for family planning services which appears to be met at least in part by CBDs.
– Where the CBD approach is used, there is usually one male and one female CBD per village. Apart from making contraceptives available in remote areas, the approach has been repeatedly noted to initiate a discussion of gender roles in the respective villages.[48]
– The component promotes making sexual and reproductive health services more youth friendly. This is particularly important given the ideologically contentious issues involved in addressing such issues within schools. However, the attitudes of health staff are not always helpful in this regard and more could be undertaken here.
– CBDs linked women that have suffered fistula as result of obstructed labour with repair surgery in Lindi regional hospital. The age of first pregnancy is still far too low and utilization of professionally assisted delivery services is less than 50%. This is due to the low status and powerlessness of women.
– The policy and practice of expelling pregnant school girls from school and not allowing them to return after the delivery is highly discriminatory. NGOs are lobbying for change, and PASHA is trying to address the issue in consultations with the Ministry of Education and Vocational Training.
– Some of the early pregnancies are likely to be caused by forced or unwanted sex.[49] Little is done to reach out to help survivors of such abuse.
– Sexual and domestic violence is a topic in the counselling provided by teachers as well as in CBD and theatre group trainings.
– GTZ/TGPSH upon request of the MOHSW did a pilot study in Tanga, Maramba ward amongst CBD clients on the need and acceptance of emergency contraceptive pills. The main clients were found to be married women of all ages. 87.6% sought the service after "sex took place without contraception" and "to avoid pregnancy", 3.7% said they had been raped.
– The TGPSH-supported website www.chezasalama.com provides sexual and reproductive health education for young people and addresses sexual rights, including advice on where to turn if one is a

[46]Traditional initiators of both sexes have an important role in preparing young men and women for their respective roles in a relationship. The TGPSH approach aims at facilitating a discussion about gender roles and questioning the traditional teachings, which, however, can be difficult: as A. Mlay explained, the teachings "are not gender-sensitive at all ... What the girls are taught is only male-centred; a girl is taught how to please a man, not herself. And the man is taught how to get satisfied, not how to please the woman." Interview on August 27, 2008. The female traditional initiators are at the same time traditional birth attendants, who receive from TGPSH biological and medical information about the reproductive organs and pregnancy-related risks. At the same the programme tries to convey the importance of sending expecting mothers to the hospital.

[47]From the students of each class, one male and one female peer educator is selected. There is usually also equal representation of women and men as counselling teachers and in the theatre groups. Interviews with D. Coppard and A. Mlay, August 29 and 27, 2008.

[48]Interview with A. Mlay, August 27, 2008. The CBDs are supposed to discuss sensitive issues including gender inequality and gender-based violence within their community, give health talks on selected sexual and reproductive health topics, and refer clients to further services. They visit individual households in pairs of one woman and one man each.

[49]Cf. e.g. WHO (2005) fact sheet.

victim of sexual violence or rape.[50] A booklet entitled "Sexual and Reproductive Rights" has been added to the series of booklets for young people. Other topics in the series include growing up, building relationships, safe sex etc. PASHA has developed a self-study guide on life-skills like communication and decision-making which is for both sexes but may help young girls in particular to strengthen their self-confidence and ability to negotiate.

Recommendations

- Continue to initiate and strengthen discussions on gender equality in peer education, theatre and cooperation with traditional initiators.
- Continue to train and support CBDs in order to make family planning services more accessible in rural areas – including for men; consider promoting the approach among other development partners and discussing how else male-friendly family planning services could be established and improved.
- Continue to support life-skills education for adolescents aimed at gender-balance and paying particular attention to the needs of girls.
- Use momentum to advocate for a change of the school girl policy, and support the respective NGO networks working on this issue.[51]
- Conduct operational research into early pregnancies and its consequences as well as the prevalence of sexual violence at schools and how it can be addressed more squarely.
- Explore the potential and develop ways of creating linkages between reproductive health services and organisations providing legal aid services at local level.
- Continue dialogue with the MOHSW on the provision of emergency contraception. Advocate for making emergency contraception widely available and consider how this could be supported by TGSPH.

Obstetric fistula is an injury of childbearing that has a devastating impact on the lives of girls and women. It particularly afflicts those who give birth whilst still very young and is usually caused by several days of obstructed labour in the absence of timely medical intervention (UNFPA, 2004). TGPSH and other partners are working to draw attention to the problem and to make surgery available in Tanzania.

According to information provided by PASHA; in Lindi and Mtwara Regions pregnancies are the reason for approximately 20 percent of the school-dropouts from primary schools.[52] The policy regarding pregnant school girls is related to the prohibition of sexual relations for below 18 year olds, and it is a very controversial issue nation-wide.[53] PASHA is participating in the policy dialogue in the education sector and

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[50] Cf. http://www.chezasalama.com.

[51] At the MET meeting on Sept. 17, WLAC confirmed that there is an NGO campaign already lobbying for change of the policy. Strengthening the implementation of re-entry policies was also recommended by the CEDAW-Committee, cf. above at 2.1 and http://www.ohchr.org/EN/countries/AfricaRegion/Pages/TZIndex.aspx.

[52] E-Mail by D. Coppard on Sept. 15, 2008, with reference to data from the Basic Education Statistics in Tanzania (BEST).

[53] There was some disagreement over the actual legal status of the policy. While different TGPSH staff members variably referred to the "law" or the "policy" on pregnant school girls, G. Chambua at TGNP claimed that legally, girls should be allowed to

has informally discussed the issue of teenage pregnancies with the MOEVT, where, however, changes were apparently not supported by all leaders. The national policy is currently being revised by the MOEVT so as to possibly allow re-admittance of pregnant teenagers to school.[54]

The findings of PASHA include that some teachers may feel more comfortable promoting abstinence rather than facilitating the communication of a broader reproductive health package of services for students. The practice of expelling pregnant girls from school without re-admittance is based on a perception that young people who start having sexual relationships early are a bad moral influence on their peers.[55]While it is questionable in any case that girls should be deprived in this way of their right to education, there is a particular irony in accusing these girls of bad morals, considering how many of the early pregnancies probably result from forced or unwanted sex and the failure to provide young people with information and services.

According to the WHO (2005) study results from Dar es Salaam and Mbeya district, the earlier girls had their first sexual experience, the more likely it was to be forced. Moreover, the findings on physical violence show that excluding those cases where girls and young women suffered physical violence from a partner, the most frequently named perpetrators were teachers.[56] Some TGPSH staff members also mentioned anecdotal evidence about teachers who forced school girls to have sex with them and then tried to make them leave the school.[57] This should be kept in mind if TGPSH facilitates a study about the circumstances and consequences of early pregnancies. Furthermore, within the framework of the peer education programme in schools, the topic of forced sex should be regularly discussed with the teachers involved, with the aim of sensitising teachers about the problem, but also of highlighting their responsibility and their possible contributions to make schools a safe environment for girls.[58]

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continue to attend school after delivery, but that the headmasters were free to decide about this – and often decided against readmitting these young mothers. In any case, the current policy has the effect that young mothers who have been expelled from a (public) school can usually only change to a private school to continue their education (Interview with D. Coppard on August 29, 2008): Even if the policy was different, the stigma associated with teenage pregnancy might still keep the majority of the affected girls from re-attending the same school (Interview with A. Mlay, August 27, 2008).

[54]Interview with D. Coppard, August 29, 2008.

[55]This appears to be a widely held view which is shared even by some representatives of major Tanzanian NGOs active in the field of sexual and reproductive health. One such representative argued in response to a controversial paper on teenage pregnancies that "we need to create enabling environment in the school institutions that promote these [African cultural] values by promoting girls and boys that do not fall prey to early sexual relationships and early pregnancies. And we can create this environment by recognising the need for girls who get pregnant to have special adult education programme financed. ... Why create a policy environment – the re-entry policy that has repercussions on the moral values on children who are not yet in that situation. ... Don't we recognise the [ ] risk of compounding the early pregnancy issue due to peer influence???"

[56]WHO (2005) fact sheet, 3. 4: "19% of all respondents in Dar es Salaam and 16% in Mbeya reported that someone other than a partner had been physically violent towards them since the age of 15. The main perpetrators were teachers, mentioned by more than half of all women who reported physical abuse."

[57]Dr. B. Schmidt-Ehry, interview on August 28, 2008, said that this would have to be substantiated by more evidence and data. D. Coppard in the interview on August 29, 2008, asserted that teenage pregnancies were a problem in the primary schools in the South of Tanzania, and that there sometimes were teachers who seduced school girls. In addition, she pointed out that school girls were also sometimes seduced to have sex with men outside the schools, with so called "sugar daddies" who would give them presents in exchange for sexual relations.

[58]On the topic of gendered practices in schools which constitute a health risk, and particularly on physical and sexual harassment and abuse in schools, cf. also Gupta et al (2003): 28, "Is schooling a risk?"

3.5 Health Financing

There are a variety of different health insurance schemes in Tanzania and the advantages and disadvantages[59] as well as the scope of these different insurance types are currently much discussed. One current task, which is supported by TGPSH as well as other stakeholders, is to establish a National Framework of Health Insurances to provide an overview of current insurance schemes and their regulatory framework with a view to their future development. Nonetheless, the majority of the Tanzanian population currently is not insured in any of the schemes and is therefore relying on out-of-pocket payments in case of falling sick.

The Health Financing (HF) Component works to support the expansion of the concept of community health funds (CHFs). The CHFs are a voluntary pro-poor health insurance scheme aimed at insuring poor people working in the formal and informal sector through small contributions each year. Each household in a district wanting to join the CHF is required to contribute the same amount of membership fee that has been determined within that district. The household then receives a CHF card which entitles household members to a basic package of curative services throughout the year.[60] The CHFs are administrated by Council Health Service Boards (CHSBs) operating at district level. The people represented in the CHSBs are health care providers as well as CHF users. HF Component activities include trainings aimed at improving management skills and accountability of the CHF administration, sensitisation of communities on the availability of CHFs and on health financing regulations generally, and advocacy at the national policy level. An important aspect is also the component's support to the district authorities in defining and applying pro-poor exemption criteria, since there are no national criteria yet developed for exemption regulations.[61]

Findings

- Community Health Funds (CHFs) are expected to enhance access and equal access to health care for men and women, but many issues in their administration and usage are still unclear; and mismanagement of the CHFs and in the health facilities may bar access.
- In TGPSH supported regions, individual CHF registration is possible which may enhance access to health care for women.
- The HF component advocated that elected community members (rather than health workers) be trained to promote the CHF and collect the funds for it. The majority of these CHF agents are women.
- According to Council Health Service Board regulations, there should be equal numbers of men and women user representatives. However, this may not be observed in practice, and CHSB requirements

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[59] E.g., the health insurance system set up so far does not yet focus on women's health as pregnancies; deliveries and post natal care are concerned. These cases are by legislation exempted. Various studies indicate that here women are disadvantaged due to the fact that provided services are not all offered free of charge and women have to do co-payments.

[60] Cf. Mtei et al (2007): 3.

[61] Exemption mechanisms are described in the CHF Act of 2001, but the criteria itself on who is poor have to be set individually by

like literacy in English may bar access for women, many of whom statistically have a lower level of education than men. The Health Financing Component in collaboration with the PPP Component has done supervisions of CHSB administration in practice and sensitised people in the districts towards observing the guidelines.

Recommendations

- Conduct operational research on current use and administration of the CHF and its effects on equity in access to health care, as well as the effects of different forms of enrolment (group vs. household or individual enrolment) on equal access to health care, to find out e.g. if individual registration cards enhance access to health services for women.
- Consider promoting a health insurance system allowing for a regulated competition of providers to enhance accountability, the criteria used should be gender sensitive – including, equal access to health care for men and women.
- Consider advocating for maternal and child health to be made priorities for the use of CHF funds.
- Discuss the feasibility of using CHF resources or creating an extra fund for the availability of emergency transport to hospitals as a means of reducing risks of labour-related complications, among other emergencies.
- Collect sex-disaggregated data on people registered in CHFs and on those renewing the inscription in order to find out about equity in using the system.
- Continue to provide trainings at local level for CHSBs and to advocate for meaningful, gender balanced participation of community representatives in local health structures and decision making processes.

There are guidelines for the use of CHF funds, but within these guidelines the CHSBs can define their own district priorities. According to the guidelines, part of the CHF money should be used to replenish drugs, with a priority on the drugs needed for pregnant women. Additional ways of using CHF money to improve maternal and child health and the availability of emergency obstetric care could be developed with the PPP and DHQM components.[62]

CHF agents are community members collecting the CHF contributions in health facilities. The majority are women as they are perceived to be more reliable and trustful and are not so often approached by people who want to borrow money. In surroundings where often men are responsible for the administration of money, it may have a positive effect on women's status to make them in charge of collecting the insurance funds.

Currently no disaggregated data are collected on the number of people registered in CHFs, but the HF

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the councils. Cf. TNCHF leaflet.

[62]Cf. above at 3.2. At the same time, of course, prioritising maternal and child health should not lead to neglecting everybody else's health or paying no attention to other types of health problems.

component suggested that this could be done in the future. Sex-disaggregated data on the number of people registered and renewing their CHF registration, as well as other information e.g. on their marriage status, could provide an important basis for assessing the impact of the CHF insurance scheme in terms of equity in access to health care.

3.6 District Health and Quality Management (DHQM)

The activities of the DHQM Component are targeted at improving the quality of health care. To this end, the component supports, for example, the introduction of hospital quality and management improvement teams and the application of a hospital quality assessment tool, as well as health care waste management, the computerisation of some hospitals, and health care technical services in order to keep hospital equipment at optimum function. It is planned to support accreditation and supervision of health facilities in the near future. The districts receive support in planning and management by the DHQM component. An important goal is to raise the number of deliveries assisted by skilled health personnel.

Findings

- Maternal mortality is the most pressing issue and a priority for the component; the low rate of professionally monitored deliveries is a focus area. Apart from problems of transport and accessibility, hospital regulations as well as atmosphere, quality of care and the attitudes of health staff are thought to keep women from attending hospitals for deliveries.[63] Issues of cultural acceptability, the position of women in society and low willingness to invest household resources compound the difficulties.[64]
- The attitudes of staff are monitored as part of the hospital assessment tools that the component and partners have developed as part of its quality management mandate. Staff attitude and ethics in health care are also addressed as a follow-up of an ethics study conducted with TGPSH support.[65]
- The National Reproductive Health System has its own quality tools and training materials that focus upon ante-natal care. Therefore, the TGPSH-DHQM component placed it emphasis upon other elements of the care delivery package, whilst still recognising the importance of quality improvement in antenatal services. Given the discrepancy between antenatal care attendance and professional monitoring of deliveries, there is still scope for further focusing ANC.
- TGPSH has supported the Tanzania Quality Improvement Framework (TQIF), which was launched by the MOHSW in 2005. One of the recommendations given in the TQIF, which the component supports, is

[63] Cf. e.g. a recent study (Mrisho et al (2007)) conducted in southern Tanzania, which combined an understanding of gender issues related to health-seeking behaviour with epidemiological knowledge concerning the venue of delivery. The study found that "issues of risk and vulnerability, such as lack of money, lack of transport, sudden onset of labour, short labour, staff attitudes, lack of privacy, tradition and cultures and the pattern of decision-making power within the household were perceived as key determinants of the place of delivery." There were substantial variations between ethnic groups with respect to the place of delivery. Also (and perhaps significantly for promoting women empowerment for health- as well as for other reasons), women who lived in male-headed households were less likely to deliver in a health facility than women in female-headed households.

[64] An example that was mentioned at the Men Engage Tanzania meeting in August 2008 was that in many hospitals the placenta is thrown away even although for cultural reasons women would like to keep it.

the introduction of the accreditation of health facilities that would, amongst other points, include the quality of maternal health care and the presence of equal opportunities policy in facilities.

- The component is developing an innovative approach to supervision in health care services which, as a positive side effect, may contribute to questioning gendered hierarchies, e.g. when female supervisors supervise male health workers.
- The component is also supporting computerisation of hospitals in cooperation with DANIDA, attention is paid to ensuring that both male and female staff are trained in their use.

Recommendations

- Strengthen the health care ethics initiative by addressing a clients' rights perspective in the quality improvement and management process.
- Consider the possibility of introducing incentives to motivate hospital midwives to welcome women, praise them for coming to deliver in the facility and to use the partograph to properly monitor deliveries. Consider the possibility of introducing incentives for community based birth attendants to refer pregnant women to health facilities, or even to start a pilot project cooperating with community based birth attendants and allowing them to attend women from their villages in hospital during delivery. [66]
- Consider advocating for change of hospital regulations so as to allow pregnant women to be accompanied by a female friend or relative at the time of delivery, at least where hospital capacity of labour rooms allows without violating the right of privacy of other women in labour.
- Use the newly introduced computerisation of hospitals to collect sex-disaggregated data on patients and subsequently evaluate data in order to find out more about gender-specific health problems and treatment as well as possible gender imbalances in hospital accessibility.[67]
- Strengthen the ability of health practitioners to recognise signs of sexual violence and whether they feel competent to address this with their patients. Wherever possible, make the aspect of recognising and thematising sexual violence an aspect of discussions and assessments regarding quality health care.
- Support the MOHSW in establishing an accreditation system as planned, and advocate for including aspects of gender relevance like the quality of maternal health care or the presence of an equal opportunities policy for staff in the accreditation criteria for health facilities.
- Together with the PPP and HF components, discuss the possibilities of improving infrastructure for transport to the hospitals and health facilities (e.g., availability of an ambulance and emergency obstetric care) consider the feasibility of providing community based birth attendants with mobile phones for emergency communication.

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[65]Cf. this page below.

[66]MOHSW (2004): Chapter 3 seems to suggest that involving community based birth attendants or the so-called "traditional birth attendants (TBAs)" more would also be an aim of the Ministry. Point 3.1.7 in this policy reads "CHMTs [Council Health Management Teams] and council authorities shall ensure that service providers including TBAs .... are provided with basic supplies and equipment for provision of quality RCH [Reproductive and Child Health] services."

- Continue to develop and implement the innovative supervision approach, keeping in mind its potential relevance for gender equality and women empowerment in the health sector, and share positive experiences and lessons learned with partners.

According to a presentation given at the MET meeting on Sept. 17, 2008 health centres in Tanzania often have little capacity to respond adequately to the needs of victims of gender-based violence. Betron (2008) pointed out that they lack formal protocols or guidelines to treat victims or provide minimal support services. There are also reports of victims sometimes being turned away by receptionists and other healthcare staff who erroneously believe that victims must present a police report form (PF3) to be treated.[68]

3.7 Public Private Partnership (PPP)

The public private partnership component supports the establishment of fora to facilitate collaboration and joint planning processes between public and private health-care service providers. In cooperation with the MOHSW, it has, for example, developed a template for service agreements between public and private providers.

Findings

- Mother and child health have been made priority issues in the PPP agreements concluded so far.
- Some religious health care providers do not offer family planning services. The availability of family planning services could be made an additional topic of PPP agreements.
- The Facility Governing Committees and Council Health Service Boards[69] are PPP decentralised bodies for improved governance, which should foster accessibility of health services to all with consideration of gender and geographical perspectives. They have been established in most districts, but their functionality needs to be improved.[70]

Recommendations

- Continue to advocate for making mother and child health priority issues of PPP agreements.
- Continue to support CHSBs and Facility Governing Committees, with regards to improving their functionality and strengthening their contribution to make health services gender-sensitive and more accessible.

All of the three councils which have signed PPP service agreements so far have included maternal health as a priority. The national template for PPP agreements includes the Tanzanian essential health package, from which the health facilities can choose priorities. Since the work of the PPP component is closely related to district health and quality management, and it is planned to merge the two components in the next TGPSH

[68] Cf. Betron (Forthcoming 2008):
[69] Which according to their guidelines should have equal representation of male and female CHF users.

programme phase, the PPP and DHQM should jointly discuss how PPP may best be used to enhance gender equality in health care provision.

3.8 Human Resources for Health

The activities of the human resources component are aimed at mitigating the severe human resources crisis in the health sector in Tanzania through capacity building, addressing the motivation of district health staff and providing incentives for health professionals to relocate to underserved regions. The component has contributed to the development of the Master of Public Health (MPH) Programme at the Muhimbili University School of Health Sciences in Dar es Salaam, a modular training course for members of the council health management teams and to the strengthening of Zonal Training Centres.

Findings

- There is a severe crisis due to the lack of skilled health personnel: it is estimated that currently only one-third of the needed health personnel is currently available.[71]
- There is a strong gender imbalance among skilled health personnel at different hierarchical levels.[72]
- The Tanzanian government has mechanisms in order to support women to subscribe to the Master course of Public Health where in case of equal qualification women are selected. In recent MPH courses, the number of students has been approximately gender-balanced. Selection of the Tanzanian participants for the InWEnt ILT[73] course occurred with a view to gender balance in case of equal qualifications.
- There is anecdotal evidence of sexual harassment and gender-based violence at the workplace in the health sector.
- Gender-specific patterns of movement may influence the availability of skilled health personnel in remote regions.

Recommendations

- Continue to advocate for a gender-balanced selection of participants in training courses.
- Initiate and support a MPH thesis exploring gender-based violence at the workplace in the health sector.
- Conduct a research on gender-specific movement patterns of health personnel to find out its impact on the availability of human resources for health services.
- (Re) assess the extent to which human rights and gender equality are addressed in the MPH and modular diploma courses.

The programme manager pointed out that due to the severe lack of skilled health personnel, some other important gender topics could only be considered in the later future. For example, for patients to be able to

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[70] E-mail by Dr. Oberlin Kisanga, Nov. 21, 2008.
[71] Interview with Dr. B. Schmidt-Ehry, August 28, 2008. Cf. McKinsey&Company 2006.
[72] McKinsey & Company 2006.
[73] International leadership training for hospital management, a one-year course in Germany facilitated by InWEnt

chose the sex of the medical staff that attend to them, but as an issue that could only really be taken into account after the human resource crisis will be solved.[74]

Several staff members of TGPSH agreed that gender roles in personal relationships, e.g. the question if a spouse should follow his/her partner moving to another location for work, probably influence the distribution of health personnel in the country. This might therefore be worth investigating in order to identify attractive incentives for both male and female health personnel to work in the most understaffed regions. The checklist compiled by the MOHSW already takes into consideration that gender may influence mobility and the availability of human resources, and suggests that a supportive policy environment should be created for health professionals to relocate with their partners and families.[75]

It was deemed likely that sexual harassment and violence against women in the health sector – providers and patients – is widespread. Supporting exploratory research in the form of an MPH thesis is intended for the future. The findings could be utilised in the future work of the DHQM component to liaise more strongly with the which ombudspersons that the Tanzanian National Strategy on gender has established within the administrative system and to whom women can report complaints about harassment and abuse[76]

3.9 Conclusion

With its established role in the health sector and with regards to the multisectoral response to HIV and AIDS TGPSH has the chance to work with its partners to more consistently promote gender equality at the strategic level. Encouraging closer interlinkage of the Ministry of Community Development, Gender and Children with the MoHSW, MoEVT and TACAIDS would streamline and focus ongoing efforts. In general, there is scope for a more systematic approach to be taken to gender mainstreaming. However, over all, the application of a gender sensitive approach is already well established and the accepted role that gender already plays in TGPSH supported activities like peer education in and out of school, CBD programmes and community sensitisation is laudable. The similar endeavour being made in new working fields is of particular interest: For example, the new role being forged for women in CHF advocacy work and lobbying that women are involved in facility governing committees and the Council Health Service Boards. All of these interventions seek to explicitly strengthen the position of girls and women as well as their access to information and services, whilst also triggering discussion and reflection about gender roles.

Maternal morbidity and mortality statistics from Tanzania continue to expose the grim reality of the position

[74]Interview with Dr. B. Schmidt-Ehry, August 28, 2008.

[75]On the first page of this checklist, it is stated that “from a human resources perspective, gender can affect who is employed, at what level in an institutional hierarchy, ...their mobility and security”. Points in the human resources section of the checklist include: “incentives and security for women and male health professionals relocating to rural areas”, “a supportive policy environment for female and male health workers to relocate with partners and families”, and “safe and protective for female and male health workers in risky environments”. Checklist for integrating gender into HSSP III, received by MOHSW and UNFPA.

of girls and women in society. Given the different instruments and focuses available to TGPSH the programme could play a greater and more innovative role in tackling this issue, in particular, carrying the issue forward in the further development of PPP agreements and in the definition of priorities for use of CHF income at the facility level offer interesting new avenues. Building alliances to advocate for the revision of legislation that doesn't conform with a human rights based approach to health is clearly a sensitive area, but one that TGPSH is well placed to engage itself with.

Efforts are underway to incorporate a human rights base approach to the entire programme. Integrating Sexual and Reproductive Health/Rights and HIV & AIDS is a particular hallmark of TPGSH and attention to gender is of recognised crucial importance in this area. There is a scope to more squarely address gender based violence and to work to ensure that health staff are better able to provide services for the survivors thereof. TGPSH has contributed to the gender-sensitive design of HIV and AIDS prevention, care and treatment in Tanzania and the strong effort to ensure male involvement.

TGPSH is also well advised to maintain and strengthen its equal opportunities policy both internally and when it comes to TGPSH-support for continuing education for staff working at the various levels of the health sector. The internal gender focus of TGPSH could be further strengthened by allocating staff responsibilities for realising gender-sensitive component objectives as part of their annual staff performance targets. This could be matched by ensuring a consistently gender sensitive approach is taken to monitoring and evaluation of the programmes intended and actual impacts. The available knowledge and experience with gender-sensitive programming within TGPSH should be shared between the programmes own staff as well as other stakeholders on a regular basis. Together with her partners, TGPSH could consider addressing existing knowledge gaps through operational research and an analysis of the findings.

[76]Cf. above, 2.1.6. and 3.3.

Annex 1

Tanzanian commitment to international agreements

ICESCR	The International Covenant on Economic, Social and Cultural Rights (ICESCR) was ratified by Tanzania in 1976. Art. 12 of ICESCR guarantees the right to the highest attainable standard of physical and mental health. According to Art. 2 II this is to be guaranteed without discrimination of any kind.
CEDAW	The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) was ratified by Tanzania in 1985. Implementation of the Convention is monitored by a UN Committee on the Elimination of All Forms of Discrimination against Women on the basis of regular reporting.
CEDAW Optional Protocol	The CEDAW Optional Protocol was ratified by Tanzania in 2006. A state hereby recognises the competence of the above mentioned Committee to receive and consider complaints from individuals or groups within its jurisdiction
Beijing Platform for Action	Tanzania is committed to implementing the Beijing Platform for Action (BPA) and the Beijing +5 Political Declaration and Outcome Document. From the BPA 12 critical areas of concern the Tanzanian Government chose the following four for immediate attention: enhancement of women's legal capacity, women's economic empowerment and poverty eradication, women's political empowerment and decision-making, and women's access to education, training and employment.
MDG 3 and 5	Tanzania is committed to achieving the Millennium Development Goals, Goal No. 3 promotes gender equality and the empowerment of women[77]. Goal No. 5 seeks improved maternal health.
SADC Declaration	As a member of the Southern African Development Community (SADC), Tanzania is also party to the SADC declaration on gender and development, which reaffirms the region's commitment to achieving gender equality.
Maputo Protocol	The Maputo Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa was ratified by Tanzania in 2007.

Tanzanian national legislation and policies

Tanzanian Constitution	The Constitution of Tanzania protects equal rights and non-discrimination.
Development Vision 2025	The Tanzanian Development Vision 2025 aspires towards achievement of a high quality livelihood for its people through the realisation of inter alia, "gender equality and the empowerment of women in all socio-economic and political relations and cultures".
National Strategy for Growth and Reduction of Poverty (NSGRP/MKUKUTA)	The National Strategy for Grown and Reduction of Poverty identifies gender as a crosscutting issue for all sectors and aims, inter alia, to reduce gender inequalities in health.
Women and Gender Development Policy (2000) and the National Strategy for Gender Development (2005)	The Tanzanian Women and Gender Development Policy and the National Strategy for Gender Development have been devised by the Ministry of Community Development, Gender and Children to "ensure that the gender perspective is mainstreamed into all policies, programmes and strategies" and to "accelerat[e] the attainment of gender equality in the country".
Employment and Labour Relations Act (2003)	The Employment and Labour Relations Act prohibits discrimination in the work place on the basis of gender, sex, marital status, disability and pregnancy among others. This law also requires employers to report to the Labour Commissioner on their plans to promote

[77] Cf. http://www.un.org/millenniumgoals/gender.shtml

	equal opportunities.
National Employment Services Act 1999	The National Employment Services Act provides for equal opportunities for women and men to access employment.
Law of Marriage Act (1971)	The Law of Marriage Act is the relevant legislation on marital relationships. It defines marriage as a voluntary union (Part II, Art. 16 I), but in (Part II, Art. 13 I) the discrepancy is found that the minimum age for marriage is 18 years for men, but just 15 years for girls/women.
Sexual Offences Special Provisions Act (1998)	Sexual Offences Special Provisions Act (SOSPA) is the relevant legislation when it comes to sexual relations. While it was celebrated by many women and human rights NGOs in Tanzania as a major achievement towards protecting women against sexual violence and rape[78], for under 18 year-olds it does not differentiate between voluntary and forced sexual relations: According to Section 130 II (e) (SOSPA Part II, replacing section 130 of the Penal Code), a male person is assumed to commit rape "if he has sexual intercourse with a girl or woman with or without her consent when she is under eighteen years of age, unless the woman is his wife who is fifteen or more years of age and is not separated from the man". According to Section 131 (1), rape is punishable with imprisonment of not less than thirty years. SOSPA also prohibits homosexual relations.
Penal Code (1981)	The Penal Code prohibits abortion, the only exceptions being cases where the health and life of the mother is endangered.[79]
Special Provision Act to the Penal Code	In 1998 a Special Provision was made to the penal code that prohibits female genital cutting (FGC). In line with the recommendation of the Beijing report, a National Plan of Action to combat FGM (2001 to 2015) was put in place. In 2002 the Government facilitated the formation of the Tanzania Chapter of the East African Network on the elimination of FGM.
National Plan of Action (2001) to combat violence against women and children	The National Plan of Action to combat violence against women and children outlines various strategies and activities to combat all forms of violence against women, girls and boys in Tanzania.
Health Sector Strategic Plan III	The Health Sector Strategic Plan III states in section 5.3 that "the MOHSW will ensure a gender focus in all policy development, guidelines and protocols", and elaborates gender sensitivity in terms of specific services needs as well as activities to stimulate equality of men and women.

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A. Criteria for country programming and project activities according to the BMZ gender equality concept[80]

"1. Country programming
The following aspects should be considered in country and regional strategies. (The brackets refer to the BMZ terms of reference for such country and regional strategies.)

- Does the description of the core problems and general environment show the difference in the living conditions of women and men?
- Have the problems in the areas of poverty, environment and education been described on a gender-specific basis and supported by data? (Chap. 1.1)
- Have the women in the partner country in question equal status to men in legal terms and are they represented in politics? Do governmental or non-governmental women's organisations exist? (Chap. 1.2)
- Does the evaluation of the present co-operation with a particular country show the differing impact that this co-operation has had on women and men? What lessons can be learned from the present co-operation in its different impact on women and men? (Chap. 2)
- How can future development co-operation contribute to gender equality? (Chap. 3)
- Is state action development-oriented from both women's and men's point of view? Does the country pursue an explicit policy of equality? If so, how (legal equality, quotas for political institutions, etc.)? (Chap. 3.1)
- Is Germany's development co-operation geared to this policy? Does it support organisations that lobby for such a policy? (Chap. 3.2)
- Is equality a subject for the policy dialogue? Are structural human rights violations against women addressed in the policy dialogue? (Chap. 5)
- As regards key co-operation sector strategies, here too it can never be assumed that activities are neutral in gender terms. Care must be taken to pursue a gender-specific approach in selecting the key co-operation sectors, designing relevant strategies and designing projects and programmes under a given strategy.

[80] BMZ (2001): 17f.

2. Project activities

When handling development projects, the following should be borne in mind:

- Do the selection of the project and the project proposal take account of the different interests and needs of women and men? Did women and men have an equal say in project selection?
- Do the project documents contain a gender analysis in the respective sectors (e.g. gender-specific division of labour, type and size of the enterprises, access to means of production such as land and credit and to services, access to basic and further training measures)? Are the conclusions from the analysis being adequately followed up in the project?
- Was the appraisal/evaluation team selected on the basis of criteria which ensure adequate consideration of gender equality?
- Has the definition of results and indicators been based on gender differentiation?
- How does the partner organisation promote the equality of women and men? In what positions and to what extent does the agency employ female staff? Does it allow equal participation of the male and female target group in the formulation and benefits of the project?
- What verifiable impact does the project have on women and men? Whose practical needs were satisfied more (e.g. in the fields of food security, employment, income, labour-saving measures, health)?
- Whose strategic interests are served better (e.g. share in the decision-making process, access to resources such as land, capital, know-how, strengthening of organisational capacities, extension of the scope of action, improvement of the legal situation)?

The sum of information received must serve to firmly establish the principle of gender mainstreaming in country programming and project work."